West Virginia Department of Health and Human Resources - Division of TB Elimination

Diagnostic Clinic Form

(This form is to be filled out for each patient being seen during clinic)

Pt Name: _____ County: _____ Clinic Date: _____

LHD Nurse: _____ *(this should be the person to contact via computer for video clinic)*

Birthdate: _____ Gender: M / F Weight: _____ Allergies: _____

Reason for attending clinic: _____

Pertinent medical history not listed below: _____

HISTORY OF:	YES	NO	HISTORY OF:	YES	NO	HISTORY OF:	YES	NO
TUBERCULOSIS			CARDIOVASCULAR PROBLEMS			GENITO-URINARY PROBLEMS		
BRONCHITIS			SEIZURES			PREGNANCY		
PNEUMONIA			DIABETES			SLEEP PROBLEMS		
ASTHMA			CANCER			HEARING/SPEECH PROBLEMS		
COPD			BONE/JOINT PAIN			BCG VACCINE		
SILICOSIS (Black lung)			IMMUNE SUPPRESSION DRUGS (TNF, steroids, etc.)			IMPAIRED IMMUNE SYSTEM		
TOBACCO USE PPD:_____			ALCOHOL/DRUG ABUSE			LIVER PROBLEMS		

SYMPTOM	YES	NO	EXPLANATION FOR ANY YES ANSWERS
COUGH			
PRODUCTIVE COUGH			
HEMOPTYSIS			
WEIGHT LOSS			
CHEST PAIN			
FATIGUE			
FEVER			
NIGHT SWEATS			

RISK FACTORS	YES	NO	EXPLANATION FOR ANY YES ANSWERS
IMMIGRANT			From:
HIV POSITIVE			
HOMELESS			
CONTACT OF AN ACTIVE CASE			
TRAVEL HISTORY			Where:
OTHER			

TST: date_____ size _____ mm IGRA: date_____ type _____ Negative/Positive

Last known TB test result and date: _____

Current Medications List was completed and faxed to DTBE prior to clinic:

YES _____ NO _____ If no why not? _____

Occupation: _____ Workplace: _____